

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN5601	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/15/2018
NAME OF PROVIDER OR SUPPLIER KNOLLWOOD MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 405 TIMES AVE LAFAYETTE, TN 37083		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments The licensure survey and was completed on 11/15/18 at Knollwood Manor. No deficiencies were cited related to the licensure survey under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Linda Austin

Administrator

11-29-18

STATE FORM

6899

G33011

If continuation sheet 1 of 1

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